PROTECTION AND ADVOCACY FOR INDIVIDUALS WITH MENTAL ILLNESS (PAIMI) PROGRAM ANNUAL PROGRAM PERFORMANCE REPORT (PPR)

Section 1. A. General Information

Fiscal Year:	2004
State:	Virginia
Name of P&A system:	Virginia Office for Protection and Advocacy
Mailing Address & Phone Number of Main Office:	1910 Byrd Avenue, Suite 5 Richmond, VA 23230
Mailing Address & Phone Numbers of for each Satellite Office:	287 Independence Boulevard, Suite 120 Virginia Beach, VA 23462 (757) 552-1148
Name of PAIMI Program, if different from the State P&A agency:	
Name, phone number, and e-mail address of the PAIMI Coordinator:	Colleen Miller Executive Director (804) 225-2042 Colleen.Miller@vopa.virginia.gov
PPR Prepared by: **Title:** **Area Code & Phone Number:** **E-mail Address:**	Sherry Confer Policy Director (804) 662-7375 Sherry.Confer@vopa.virginia.gov
President of the Governing Board **Area Code & Phone Number:** **Email Address:**	Maureen Hollowell (757) 461-8007 Maureenhol@aol.com
Date submitted:	December 29, 2004

SECTION I.PAIMI PROGRAM GENERAL INFORMATION

B. Governing Board, Advisory Council and PAIMI Staff (on 9/30)

1. Does the P&A have a multi-member Governing Board? (If Yes, complete the Governing Board columns of the Table in B 3.) [See 42 CFR Part 51.22 - Governing Authority]	Yes X	No ____
2. Is the Chair of the PAIMI Advisory Council a member of the board? (If No, please explain.) *The VOPA PAIMI Advisory Council Chair does not have voting privileges.	Yes X*	No ____

3. In the following table, please provide the requested information for the PAIMI Advisory Council (AC) and the Governing Board members. Indicate one (1) Primary identification for each member as of 9/30.

	Advisory Council	Governing Board
a. Total Number of Member Seats Available* **	15-20	13
b. Total Members Serving on 9/30 of Fiscal Year	13	10
c. Total Number of Vacancies on 9/30	2-8	1
Term of Appointment (Number of years)	4	4
Maximum Number of Terms a Member may Serve	1	1
Frequency of Meetings	Quarterly	Quarterly
Number of Meetings Held in the Fiscal Year	4	5
% (Average) of Members Present at Meetings	67%	81%
Recipients/Former Recipients (R/FR) of Mental Health Services*	6	2
Family Members of R/FR of Mental Health Services*	3	3
Mental Health Professionals*	2	1
Mental Health Service Providers*	0	0
Attorneys*	2	2
Individuals From the Public Knowledgeable About Mental Illness*	0	1
Guardians or Authorized Advocates**		0
Advocates**		4
Other Persons Who Broadly Represent or Are Knowledgeable About the Needs of Mentally Ill Individuals		1
Total	13	12 (we have 1 vacancy)

C. PAIMI Program Staff:

1. Provide the total number of P&A staff who are paid either partially or totally with PAIMI Program funds, including PAIMI Program income. Total: 29	
a. How many of the staff listed above are attorneys? **Total:** 11	b. How many of the staff listed above are non-attorney case workers/mental health advocates? **Total:** 3

2. Ethnicity/Race	**Staff**	**Advisory Council**	**Governing Board**
American Indian/ Alaska Native			
Asian			1
Black/African American	3		1
Hispanic or Latino			
Native Hawaiian/Other Pacific Islander			
White	26	13	10
Vacancies on 9/30		2-8	1
Total	29	13	13

3. Gender	**Staff**	**Advisory Council**	**Governing Board**
Male	10	5	6
Female	19	8	4
Total	29	13	10

SECTION II. PAIMI PROGRAM GOALS AND OBJECTIVES

Goal 1: People with Disabilities are Free from Abuse and Neglect

Focus Area #1: Inappropriate medication in Mental Health Institutions

Objective #1: Conduct one patient training at each state mental health institution to inform patients of their rights concerning medication.

For each indicator of success, provide the following information:

a. Focus #1 Objective #1
b. Objective was: Met
c. Base Measure used to determine whether priority was met: 9 institutions
d. Target population: patients of mental health institutions in Virginia
e. Outcome: patients of 9 mental health institutions in Virginia who participated in the training received information about their rights concerning medication

Virginia Office for Protection and Advocacy (VOPA) staff presented at least one training session at each of the nine (9) state mental health institutions. Training included patient rights concerning medication and the right to informed consent. Following presentations, several patients requested and were provided additional information and technical assistance, including detailed information concerning the role of a legally authorized representative (LAR) and court-ordered treatment in the context of a medication/informed consent issue, better equipping patients for self-advocacy or otherwise resulting in VOPA case level services as needed.

In addition, pursuant to a federal court settlement, the VOPA provided quarterly rights training for patients in the Department of Veterans Affairs Hospital in Richmond, Virginia.

Goal 1: People with Disabilities are Free from Abuse and Neglect

Focus Area #1: Inappropriate Medication in Mental Health Institutions
Objective #2: Investigate ten (10) complaints from patients of mental health institutions where there is probable cause to believe that medication is administered without informed consent. If violations are found, represent the patients to prevent continued violation of the residents' rights.

For each indicator of success, provide the following information:

a. Focus #1 Objective #2
b. Objective was: Met
c. Base Measure used to determine whether priority was met: 10 complaints
d. Target population: patients of mental health institutions in Virginia
e. Outcome: systemic reform

VOPA staff completed fourteen (14) investigations of allegations of medication without informed consent. In one case, a patient of a state mental health institution complained to VOPA, who was on-site at the institution, that she was being forced to take psychotropic medications against her will. After obtaining consent to review the patient's records, VOPA immediately reviewed the record and concluded that the patient was being medicated without informed consent. VOPA presented the issue to the patient's doctor and the involuntary medication ceased. In another case, VOPA successfully advocated for appointment of a legally authorized representative and further assured that medication decisions were made only after full explanation to the authorized representative and receipt of the authorized representative's decision. Finally, in two cases, VOPA obtained agreements from two separate state mental health institutions to implement comprehensive staff training to assure full understanding and implementation of informed consent requirements. This systemic reform favorably impacts an on-going average census of 240 patients.

In addition, VOPA has achieved reversal of decisions to medicate based on alleged "emergency exceptions" to the informed consent requirements; an alleged routine practice used to order medications "just in case" an individual may need them. This allowed ward staff to administer the emergency medications without obtaining informed consent. Besides reversal of specific, inappropriate "emergency exceptions," one institution instructed all medical staff, regarding criteria for administration of medication under the emergency exception, ("risk of significant deterioration" is not adequate, but risk of substantial property damage" is). This systemic reform favorably affects an ongoing average census of 100 patients.

Goal 1: People with Disabilities are Free from Abuse and Neglect

Focus Area 2: Staff on Patient Assaults in State Mental Health Institutions
Objective #1: Review all Critical Incident Reports submitted by State Mental Health Institutions.

For each indicator of success, provide the following information:

a. Focus #2 Objective # 1
b. Objective was: Met
c. Base Measure used to determine whether priority was met:

VOPA staff read each Critical Incident Report (CIR) that is submitted by the State institutions. There is not a known number to establish a base measure.

d. Target population: patients of mental health institutions in Virginia who experienced an injury that rose to the level of CIR.
e. Outcome: All CIRs were read and entered into a database.

By statute, VOPA receives Critical Incident Reports (CIR) submitted by the mental health institutions. Every CIR is read by VOPA staff and pertinent information is entered into a database. All CIR that involve injuries within current program priorities and other alarming or unusual reports are identified and further reviewed. In addition, the VOPA Executive Director conducts a weekly meeting to address the reports, their implications, and remedial action.

In conjunction with VOPA's review of CIR, VOPA routinely requests that the Department of Mental Health, Mental Retardation and Substance Abuse Services (DMHMRSAS) produce internal investigation reports and supporting materials. Early in the fiscal year, DMHMRSAS began broad and inappropriate redaction of internal investigation reports that had previously been provided without redacting. VOPA objected on legal grounds and inappropriate redaction of the internal investigation reports ended.

Goal 1: People with Disabilities are Free from Abuse and Neglect

Focus Area #2: Staff on Patient Assaults in State Mental Health Institutions
Objective #2: Conduct preliminary inquiries of Critical Incident Reports that involve alleged staff on patient assaults resulting in serious bodily injury or loss of consciousness requiring medical treatment.

For each indicator of success, provide the following information:

a. Focus #2 Objective #2
b. Objective was: Met
c. Base Measure used to determine whether priority was met: A base measure was not established as the effort is contingent upon the content of the reports received.
d. Target population: patients of mental health institutions in Virginia who experienced an injury that rose to the level of CIR
e. Outcome: systemic reform

Five preliminary inquiries related to Critical Incident Reports or other complaints from State mental health institutions have been completed. Based on the preliminary inquiry results, four investigations have been opened and completed. In one case, a patient was strip searched in a manner that violated the Virginia Department of Mental Health, Mental Retardation and Substance Abuse Services' Human Rights Regulations. As a result of VOPA's inquiry and investigation, the institution initiated and has implemented broad-based reforms, including changes to the search policies and procedures (changes were designed to increase patient safety and protect patient dignity and rights), the addition of specific policy provisions addressing body cavity searches, new required trainings for all direct care nursing staff and security personnel (at least 70 such employees have been trained to date), and the establishment of annual nursing "Competencies" which require direct care nursing staff to demonstrate a working knowledge of the patient search criteria and procedures each year, as a condition of their employment. This systemic reform favorably affects an average census of 100 patients.

Goal 1: People with Disabilities are Free from Abuse and Neglect

Focus Area #2: Staff on Patient Assaults in State Mental Health Institutions
Objective #3: Conduct full investigations of five (5) Critical Incident Reports identified in #2 above that are selected for preliminary inquiry where there is probable cause to believe that abuse or neglect occurred. If violations are found, take appropriate action.

For each indicator of success, provide the following information:

a. Focus #2 Objective #3
b. Objective was: Met
c. Base Measure used to determine whether priority was met: 5 investigations
d. Target population: patients of mental health institutions in Virginia who experienced an injury that rose to the level of CIR
e. Outcome: systemic reform

The objective to conduct full investigations of five (5) CIR includes investigation of reports from both State mental health and State mental retardation institutions. A total of six investigations of such reports and complaints were completed, four of which involved mental health facilities. See narrative for goal 1, focus area 2, objective 2 above.

Goal 1: People with Disabilities are Free from Abuse and Neglect

Focus Area #2: Staff on Patient Assaults in State Mental Health Institutions
Objective #4: Conduct quarterly trend analyses to determine whether staff on patient assault is more prevalent at specific mental health institutions and, if so, conduct systemic investigations of such institution. If violations are found, take action to reduce such violations.

For each indicator of success, provide the following information:

a. Focus #2 Objective #4
b. Objective was: Met
c. Base Measure used to determine whether priority was met: Quarterly trend analyses
d. Target population: patients of mental health institutions in Virginia who experienced an injury that rose to the level of CIR
e. Outcome quarterly trend analysis conducted

VOPA conducts quarterly trend analyses of Critical Incident Reports received from State institutions. The trend analyses address a wide variety of potential trends, including type of injury, location of injury, time of day and day of the week, staffing, and other areas. Trend analyses are continuing and are being refined to account for variations, including the number of patients in one institution compared to the number in another institution, and other potential variables to assure accurate comparisons of trends between the various institutions. The VOPA Executive Director conducts a weekly meeting with VOPA staff to discuss CIR, their implications, quarterly trend analyses and potential remedial actions.

Goal 1: People with Disabilities are Free from Abuse and Neglect

Focus Area #3: Abuse and Neglect in Community Settings
Objective #1: Investigate five (5) instances of alleged abuse and neglect in community settings that are licensed by the Department of Mental Health, Mental Retardation and Substance Abuse Services that involve serious bodily injury or loss of consciousness requiring medical treatment where there is probable cause to believe that such abuse or neglect occurred, or where there was inappropriate use of seclusion or restraint, and take appropriate action.

For each indicator of success, provide the following information:

a. Focus #3 Objective # 1
b. Objective was: Met
c. Base Measure used to determine whether priority was met: 5 investigations
d. Target population: PAIMI eligible individuals receiving services in community settings licensed by the Department of Mental Health, Mental Retardation and Substance Abuse Services
e. Outcome: 10 investigations have been completed

VOPA has worked on 14 investigations and ten have been completed with follow-up action where abuse or neglect was found. They included private psychiatric facilities, a group home, an assisted living facility, a school, and a nursing home.

In one investigation, VOPA's investigation uncovered theft of prescription medications, physical abuse, and neglect of an individual's medical needs who later died, and false entries in medical records. VOPA has filed suit for an injunction against further abuse and neglect. The litigation is ongoing. This facility is licensed for 41 beds. If the litigation is successful, the result will be systemic in nature, both to the subject facility and hundreds of similar facilities in Virginia.

Goal 1: People with Disabilities are Free from Abuse and Neglect

Focus Area #4: Inappropriate Restraint Use in Juvenile Detention Facilities and Schools
Objective #1: Inform Juvenile facilities of VOPA's authority and objectives.

For each indicator of success, provide the following information:

a. Focus #4 Objective #1
b. Objective was: Met
c. Base Measure used to determine whether priority was met: 1 mailing to 140 providers
d. Target population: PAIMI eligible individuals in juvenile detention facilities and schools
e. Outcome: Participants in training sessions at the Summit received information about disability rights.

VOPA completed a mailing to juvenile facilities that included clarification of VOPA's right to access.

VOPA participated in the Parent Educational Advocacy Training Center workgroup that planned a Juvenile Justice Summit in May 2004. VOPA staff presented on challenges facing children in Juvenile Justice facilities. Specifically, VOPA discussed the rights such children have to receive transition planning and vocational training.

Goal 1: People with Disabilities are Free from Abuse and Neglect

Focus Area #4: Inappropriate Restraint Use in Juvenile Detention Facilities and Schools
Objective #2: Conduct preliminary inquiries of complaints that allege inappropriate restraint use in juvenile facilities and schools that result in serious bodily injury or loss of consciousness requiring medical treatment.

For each indicator of success, provide the following information:

a. Focus #4 Objective #2

b. Objective was: Met

c. Base Measure used to determine whether priority was met: A base measure was not established as VOPA conducted preliminary inquiries on every complaint received.

d. Target population: PAIMI eligible individuals in juvenile detention facilities and schools

e. Outcome: systemic reform

VOPA conducted a preliminary inquiry of a complaint alleging inappropriate seclusion of an adolescent patient in a Psychiatric Residential Treatment Facility (PRTF). As a result of the preliminary inquiry, a full investigation was opened. For results see Goal 1, Focus Area 4, Objective 3 below.

Goal 1: People with Disabilities are Free from Abuse and Neglect

Focus Area #4: Inappropriate Restraint Use in Juvenile Detention Facilities and Schools
Objective #3: Investigate five (5) instances of such allegations where there is probable cause to believe that abuse or neglect occurred. If abuse or neglect is found, report findings.

For each indicator of success, provide the following information:

a. Focus #4 Objective #3

b. Objective was: Met

c. Base Measure used to determine whether priority was met: 5 investigations

d. Target population: PAIMI eligible individuals in juvenile detention facilities and schools

e. Outcome: systemic reform

VOPA conducted a full investigation of a complaint of inappropriate seclusion of an adolescent patient in a Psychiatric Residential Treatment Facility (PRTF). The investigation revealed that, while the time spent in seclusion was not excessive given the applicable regulations and the child's dangerous behavior toward others, the lack of active treatment provided during seclusion was inappropriate. As a result of VOPA's investigation and demand for change, the PRTF revised its policies to include a requirement for active treatment during extended periods of seclusion, a requirement for documentation of the active treatment provided, and a requirement for training on ways to decrease the use of seclusion and restraint and the provision of active treatment.

In a separate investigation, VOPA investigated allegations of inappropriate restraint of students at a private school serving students with mental illness. The investigation confirmed the inappropriate restraint and the school agreed to systemic reform, including termination of employees who engaged in inappropriate restraint and adoption of a new restraint procedure that places greater emphasis on verbal de-escalation.

In another investigation, several employees of the Department of Medical Assistance Services, Department of Social Services, and DMHMRSAS reported recurring instances of possible abuse at a facility in Leesburg. VOPA collected multiple records of complaints against the facility and contacted individuals mentioned in those records. VOPA also contacted management and staff, as well as the Fairfax County Police. VOPA successfully facilitated the transfer of two individual minor clients from the facility to a residential school. VOPA attempted to work in conjunction with Child Protective Services and the Police to investigate the facility with greater scrutiny. After our initial inquiries, the facility was sold to a new entity and restructured.

Goal 1: People with Disabilities are Free from Abuse and Neglect

Focus Area #4: Inappropriate Restraint Use in Juvenile Detention Facilities and Schools
Objective #4: Identify two (2) schools that subject children with disabilities to in-school suspensions, "time-outs" and other restraints and do not provide those children with appropriate Positive Behavioral Supports and Interventions. Initiate litigation and/or other advocacy to change this practice.

For each indicator of success, provide the following information:

a. Focus #4 Objective # 4
b. Objective was: Met
c. Base Measure used to determine whether priority was met: 2 schools
d. Target population: PAIMI eligible individuals in schools
e. Outcome: systemic reform

VOPA has completed one investigation of a school and is conducting another. In the first, an elementary school refused to provide positive behavioral support and services for a child prior to engaging in disciplinary actions. VOPA first obtained a favorable resolution for the child and then investigated the way the school acted in similar cases. VOPA demanded that the school receive specific training to avoid further improper disciplinary actions. The school agreed and has already received the training. In the other case, a school sought to expel a child and insisted that, despite his disabilities, the child was not eligible for special education. VOPA first represented the child and successfully advocated for him to be found eligible for special education, resulting in the child not being expelled. VOPA then investigated the school and found that its special education determinations were based on flawed and illegal methods. As a result, it is possible that several students were improperly disciplined because they were not found eligible for special education. VOPA is currently advocating, and will take more aggressive steps if necessary, to ensure that the school and district properly consider children's disabilities during disciplinary procedures.

Goal 1: People with Disabilities are Free from Abuse and Neglect

Focus Area #4: Inappropriate Restraint Use in Juvenile Detention Facilities and Schools
Objective #5: Determine from review of available data whether there is extensive use of physical restraints in public schools.

For each indicator of success, provide the following information:

a. Focus #4 Objective #5
b. Objective was: Met
c. Base Measure used to determine whether priority was met: review was completed
d. Target population: PAIMI eligible individuals in public schools
e. Outcome: working for systemic reform

VOPA has researched Department of Education's (DOE) responsibility to ensure that public schools do not inappropriately use seclusion and restraint methods and are required, by statute, to develop guidelines for public schools to use in developing seclusion and restraint policies of their own. VOPA has, through the Freedom of Information Act, requested, received and reviewed the policies of several schools and found that many schools do not have policies, even though they do restrain students. VOPA has also reviewed DOE's draft guidelines on the use of seclusion and restraint by public schools and its existing regulations on the use of seclusion and restraint by private schools. Whereas DOE holds private schools to a very high standard – the Human Rights Regulations of the Department of Mental Health, Mental Retardation and Substance Abuse Services, its draft guidelines for public schools are nowhere near as stringent. VOPA will comment on the proposed standards and demand that DOE hold public schools to the same requirements as it does private schools. Also, whenever VOPA receives a case involving school restraint, it reviews the restraint policy of the school to determine whether it is appropriate.

Goal 1: People with Disabilities are Free from Abuse and Neglect

Focus Area #5: Deaths Where There is Probable Cause to Believe Abuse or Neglect Occurred
Objective #1: Complete all outstanding non-systemic abuse and neglect investigations pending on October 1, 2003 by March 1, 2004.

For each indicator of success, provide the following information:

a. Focus #5 Objective #1
b. Objective was: Met
c. Base Measure used to determine whether priority was met: 9 pending investigations
d. Target population: PAIMI eligible individuals
e. Outcome: 9 investigations completed

As a result of VOPA's restructuring from grant program-based to task-based units, this objective was established to complete all non-systemic abuse and neglect investigations that were pending on the date of the restructuring. All such pending investigations were completed timely and appropriate remedial action was taken.

Goal 1: People with Disabilities are Free from Abuse and Neglect

Focus Area #5: Deaths Where There is Probable Cause to Believe Abuse or Neglect Occurred
Objective #2: Review all Critical Incident Reports submitted by state mental health institutions.

For each indicator of success, provide the following information:

a. Focus #5 Objective #2
b. Objective was: Met
c. Base Measure used to determine whether priority was met: A base measure was not established as the effort is contingent upon the content of the reports received.
d. Target population: patients of mental health institutions in Virginia who experienced an injury that rose to the level of CIR
e. Outcome: All CIR were read and entered into a database

VOPA receives Critical Incident Reports (CIR) submitted by the mental health institutions. Every CIR is read by VOPA staff and pertinent information is entered into a database. All CIR that involve injuries within current program priorities and other alarming or unusual reports are identified and further reviewed. In addition, the VOPA Executive Director conducts a weekly meeting with VOPA staff to address the reports, their implications and remedial action.

Goal 1: People with Disabilities are Free from Abuse and Neglect

Focus Area #5: Deaths Where There is Probable Cause to Believe Abuse or Neglect Occurred
Objective #3: Conduct preliminary inquiries of Critical Incident Reports that report a death occurred in a state mental health institution where there is reason to suspect abuse or neglect.

For each indicator of success, provide the following information:

a. Focus #5 Objective #3
b. Objective was: Met
c. Base Measure used to determine whether priority was met: A base measure was not established as the effort is contingent upon the content of the reports received
d. Target population: patients of mental health institutions in Virginia who experienced an injury that rose to the level of CIR
e. Outcome: All CIR reporting a death in a state mental health institution were reviewed, and where appropriate, were opened for preliminary inquiry.

One preliminary inquiry involved a death at a State operated mental health institution. The preliminary inquiry revealed indications of abuse and neglect relating to the administration of psychotropic medication, monitoring of the individual while in seclusion and staffing. A full investigation was opened. See narrative at Goal 1, Focus Area 5, Objective 4, paragraph 3, for results of the full investigation.

Goal 1: People with Disabilities are Free from Abuse and Neglect

Focus Area #5: Deaths Where There is Probable Cause to Believe Abuse or Neglect Occurred
Objective #4: Conduct a full investigation of two (2) Critical Incident Reports in #3 above where there is probable cause to believe that abuse or neglect occurred and take appropriate action.

For each indicator of success, provide the following information:

a. Focus #5 Objective #4
b. Objective was: Met
c. Base Measure used to determine whether priority was met: 2 investigations
d. Target population: patients of mental health institutions in Virginia who experienced an injury that rose to the level of CIR
e. Outcome: systemic reform

Four death investigations have been conducted. Three have been completed with recommendations to the facility.

One investigation revealed significant failure by the facility to conduct essential medical tests and failure to provide needed services by primary care physicians. VOPA found that both failures contributed to a patient's death, caused by gangrene infection, and constituted abuse or neglect. As a result of the investigative findings, VOPA recommended substantial systemic corrective action, including mandatory, annual primary care medical training for facility psychiatrists and mandatory and specific follow-up of abnormal laboratory test results. All recommendations have been accepted by the facility and implemented.

Another investigation uncovered numerous instances of medication without informed consent, inadequate staffing and failure to conduct required monitoring while a patient was secluded. A formal administrative complaint was filed and the facility has agreed to needed systemic reforms.

Goal 1: People with Disabilities are Free from Abuse and Neglect

Focus Area #5: Deaths Where There is Probable Cause to Believe Abuse or Neglect Occurred

Objective #5: Conduct preliminary inquiries of complaints that report a death in a community setting where there is reason to suspect abuse or neglect.

For each indicator of success, provide the following information:

a. Focus #5 Objective #5

b. Objective was: Met

c. Base Measure used to determine whether priority was met: A base measure was not established as the effort is contingent upon the number of complaints received

d. Target population: PAIMI eligible individuals living in the community whose death may be related to abuse or neglect.

e. Outcome: Preliminary inquiries of complaints involving death in a community based facility were completed.

Two preliminary inquiries of deaths in community based facilities were completed. One revealed probable cause to believe abuse or neglect occurred and was opened as a full investigation.

Goal 1: People with Disabilities are Free from Abuse and Neglect

Focus Area #5: Deaths Where There is Probable Cause to Believe Abuse or Neglect Occurred
Objective #6: Conduct a full investigation of one (1) incident in #5 above where there is probable cause to believe that abuse or neglect occurred and take appropriate action.

For each indicator of success, provide the following information:

a. Focus #5 Objective #6

b. Objective was: Met

c. Base Measure used to determine whether priority was met: 1 investigation

d. Target population: PAIMI eligible individuals living in the community

e. Outcome: Successful completion of investigation resulting in appropriate remedial action

VOPA conducted an investigation of a death in a community-based facility and, based on the results of the death investigation and discovery of other violations at the facility, a lawsuit seeking injunctive relief was filed. The litigation is pending.

Goal 2: Children and Youth with Disabilities Receive an Appropriate Education

Focus Area #1: Transition Services for Children Age 14 and Above
Objective #1: Provide legal representation for fifteen (15) children who have been denied transition planning that promotes movement from school to post-school activities.

For each indicator of success, provide the following information:

a. Focus #1 Objective #1
b. Objective was: Met
c. Base Measure used to determine whether priority was met: 5 children
d. Target population: PAIMI eligible children needing transition services
e. Outcome: children's needs were met

As a part of VOPA's representation in transition cases, attorneys examine the role of Disability Service Agencies to ensure that they are fulfilling their obligation to provide transition planning. VOPA has represented over 15 children in transition cases. VOPA has also received complaints and evidence suggesting that the Virginia Department of Rehabilitative Services is not meeting its obligation to provide transition planning or services, including functional behavioral assessments. VOPA served a Notice of Potential Litigation on the Department, informing it of the complaints it received and demanding that the Department fulfill its obligations. In several individual cases, VOPA has demanded that the Department take a more active role. For example, in one case, the Department did not have any client involvement, even though the child was over 16. After VOPA demanded additional involvement by the Department, additional resources were found to provide the child with the services he needed. Settlement negotiations with the Department are ongoing.

Goal 2: Children and Youth with Disabilities Receive an Appropriate Education

Focus Area #1: Transition Services for Children Age 14 and Above
Objective #2: Represent two (2) residents of juvenile detention facilities whose Individualized Education Program (IEP) contains no transition planning

For each indicator of success, provide the following information:

a. Focus #1 Objective #2
b. Objective was: Met
c. Base Measure used to determine whether priority was met: 2 residents
d. Target population: PAIMI eligible individuals needing transition services who are residing in juvenile detention facilities
e. Outcome: juvenile's needs were met

In one case, VOPA successfully participated in IEP development including an appropriate transition plan.

Goal 2: Children and Youth with Disabilities Receive an Appropriate Education

Focus Area #2: Children placed in Interim Alternative Educational Placements Due to Disability
Objective #1: Provide legal representation to seven (7) children with disabilities in order to decrease inappropriate placements in interim alternative educational placements. VOPA's representation will focus on securing the provision of appropriate Functional Behavioral Assessments and other procedural due process protections.

For each indicator of success, provide the following information:

a. Focus #2 Objective #1
b. Objective was: Met
c. Base Measure used to determine whether priority was met: 7 children
d. Target population: PAIMI eligible children
e. Outcome: children's needs were met

VOPA has represented 9 children in this area. In one notable case, a school tried to suspend a child for improper behavior. The school argued that the child was not eligible for special education (and therefore was not entitled to a Functional Behavioral Assessment) because, even though he has bipolar disorder and is failing, he does not meet the requirements of the IDEA. VOPA retained two experts to review the case and prepared a Due Process petition. The investigation is ongoing.

Goal 2: Children and Youth with Disabilities Receive an Appropriate Education

Focus Area #4: Technical Assistance to Private Bar, Legal Services Agencies, and Parent Advocacy Groups Regarding Changes in the Individuals with Disabilities Education Act (IDEA)
Objective #1: Represent interests of persons with disabilities to the Statewide Special Education Advisory Committee.

For each indicator of success, provide the following information:

a. Focus #4 Objective #1
b. Objective was: Met
c. Base Measure used to determine whether priority was met: Quarterly meetings
d. Target population: PAIMI eligible children and youth in public schools
e. Outcome: On-going committee awareness of disability rights related to special education

VOPA attends the quarterly meeting of the Statewide Special Education Advisory Committee. This committee is required by the Federal government as a first step in Federal Continuous Improvement Monitoring Process. Discussions have included Personnel Licensure Issues, completion and submission of the Federal Annual Performance Report, IDEA Reauthorization, State Assessment Update and a State Improvement Grant.

Goal 2: Children and Youth with Disabilities Receive an Appropriate Education

Focus Area #4: Technical Assistance to Private Bar, Legal Services Agencies, and Parent Advocacy Groups Regarding Changes in the Individuals with Disabilities Education Act (IDEA)
Objective #2: Develop a publication identifying the changes in the Individuals with Disabilities Education Act within 60 days of Congress amending IDEA.
Objective #3: Develop and give three (3) presentations that are tailored to meet the needs of the identified audiences within 30 days of the development of the publication noted in Objective #2.

Objective #4: Inform identified audiences via a mailing of posters and publications, within 60 days of the development of the publication in Objective #2 above, of VOPA's availability to provide training.

For each indicator of success, provide the following information:

a. Focus #4 Objective #2, 3, 4
b. Objective was: Partially Met/Continuing
c. Base Measure used to determine whether priority was met: 60 days from the IDEA amendment
d. Target population: PAIMI eligible individuals in schools
e. Outcome: information, referral, technical assistance and presentations provided

Progress in this area remains limited due to the activities at the Federal government level surrounding IDEA. However, all VOPA staff have continued to provide information and referral, technical assistance, and presentations about IDEA as it stands.

Goal 3: People with Disabilities Have Equal Access to Government Services

Focus Area #1: Law Enforcement Agencies Recognize the Needs of Persons with Disabilities
Objective #1: Identify a program in the southwestern area of Virginia that is focused on law enforcement agencies responding appropriately to persons with mental illness who are in crisis, including persons who are homeless. Support and seek to expand this program.

For each indicator of success, provide the following information:

a. Focus #1 Objective #1
b. Objective was: Met
c. Base Measure used to determine whether priority was met: 1 program
d. Target population: PAIMI eligible individuals in crisis who have contact with law enforcement agencies.
e. Outcome: Task force members have been provided information related to disability rights.

At the request of the VOPA PAIMI Advisory Council, VOPA participates in a task force to bring "Memphis Model" type police training to the Roanoke area of Virginia. VOPA has advised task force members on the law and made itself available for collaboration. The Task Force is made up of advocates, attorneys, health care providers and law enforcement representatives; it is designed to teach police ways to interact with persons with mental illness who are in crisis. The goal is to make arrest a last option, rather than a first. It is hoped that, through the program, police will recognize the needs of people in crisis and help them receive services.

Goal 4: People with Disabilities Live in the Most Integrated Environment Possible

Focus Area #1: Appropriate Services and Supports to Enable People to Move into the Community

Objective #1: Conduct one (1) patient training at each State mental health institution regarding available community services and how to access the services.

For each indicator of success, provide the following information:

a. Focus #1 Objective # 1
b. Objective was: Met
c. Base Measure used to determine whether priority was met: 9 State mental health institutions.
d. Target population: PAIMI eligible individuals living in State mental health institutions
e. Outcome: PAIMI eligible individuals living in State mental health institutions who attended the trainings received information about disability rights specifically related to community services and how to access them.

As part of larger presentations concerning patient rights, VOPA has provided patient trainings at state mental health institutions about available community resources and how to access them. As a direct result of these presentations, VOPA has received requests for services in various areas. Staff report being approached by numerous individuals following presentations with requests for assistance. The typical Technical Assistance that results is providing detailed information regarding the discharge planning process so that the individual is better equipped for self-advocacy or explaining court-ordered treatment or the role of a Legally Authorized Representative.

Goal 4: People with Disabilities Live in the Most Integrated Environment Possible

Focus Area #1: Appropriate Services and Supports to Enable People to Move into the Community

Objective #2: Identify five (5) unlicensed care facilities for the aged that house persons with disabilities and provide VOPA information.

For each indicator of success, provide the following information:

a. Focus #1 Objective # 2
b. Objective was: Partially Met/Continuing
c. Base Measure used to determine whether priority was met: 5 unlicensed care facilities
d. Target population PAIMI eligible individuals living in unlicensed care facilities
e. Outcome: objective is being continued

VOPA Board members noted this as a significant concern during the public comment period in the summer of 2003. VOPA has had difficulty identifying the facilities as they are unlicensed and no single entity monitors/regulates them. In addition, their existence as a "care facility" is difficult to distinguish from simple "housing".

Goal 4: People with Disabilities Live in the Most Integrated Environment Possible

Focus Area #1: Appropriate Services and Supports to Enable People to Move into the Community

Objective #3: Investigate process of conducting PASARR (pre-admission screenings) to determine if there is evidence of an institutional bias or other violations of law.
For each indicator of success, provide the following information: a. Focus #1 Objective #3 b. Objective was: Met c. Base Measure used to determine whether priority was met: a review was completed d. Target population: PAIMI eligible individuals living in nursing homes e. Outcome: VOPA reviewed the PASARR processes and determined that, while there is no inherent institutional bias in the process, the way the screenings are conducted should be monitored.
VOPA conducted a review of the law and procedures surrounding PASARR screenings. VOPA concluded that, while there is no inherent bias in the process, the way the process is conducted may lead to more nursing home placements than necessary. VOPA will monitor nursing home placements to determine whether persons are improperly or inappropriately placed in such facilities and take appropriate action.

Goal 4: People with Disabilities Live in the Most Integrated Environment Possible
Focus Area #2: Appropriate and Timely Discharge Plans at Mental Health Facilities Objective #1: Conduct one (1) patient training at each State mental health institution regarding discharge planning rights.
For each indicator of success, provide the following information: a. Focus #2 Objective #1 b. Objective was: Met c. Base Measure used to determine whether priority was met: 9 institutions d. Target population: PAIMI eligible individuals residing in State mental health institutions e. Outcome: Training participants received information about disability rights
VOPA has provided training for patients regarding discharge planning and has identified persons ready for discharge. Staff report being approached by numerous individuals following presentations with requests for assistance. The typical Technical Assistance that results is providing detailed information regarding the discharge planning process so that the individual is better equipped to for self-advocacy, explaining the role of a Legally authorized Representative, or court-ordered treatment.

Goal 4: People with Disabilities Live in the Most Integrated Environment Possible
Focus Area #2: Appropriate and Timely Discharge Plans at Mental Health Facilities Objective # 2: Identify ten (10) patients of State mental health institutions who remain in such institutions more than 90 days after being found ready for discharge.

For each indicator of success, provide the following information:

a. Focus #2 Objective #2

b. Objective was: Met

c. Base Measure used to determine whether priority was met: 10 patients

d. Target population: PAIMI eligible individuals residing in State mental health institutions.

e. Outcome: individuals' discharge needs were met

VOPA's litigation against the Virginia Department of Mental Health, Mental Retardation and Substance Abuse Services (DMHMRSAS) has resulted in an historic order giving VOPA access to the names and contact information of all those persons with mental illness deemed "ready for discharge" from DMHMRSAS' State mental health institutions. This case was the first in the history of the PAIMI Act to require such access and the first to define "neglect" as the failure to create or implement appropriate discharge plans. As a direct result of VOPA's action, dozens of people have been successfully discharged, some with VOPA's direct action, others through the implementation of appropriate discharge planning. VOPA is contacting people on the "ready for discharge" list and has opened five cases for people who appear on the list (who were not known to VOPA before VOPA received the list). Each person had a discharge plan that should have been, but was not, implemented. In each case, VOPA wrote letters to DMHMRSAS and Community Services Boards demanding the discharge of its client. In each case, DMHMRSAS responded by ensuring the discharge of each person.

VOPA represented a child who was identified as ready for discharge but did not have an appropriate discharge plan. VOPA intervened on her behalf, ensured that a plan was put in place and advocated, successfully, for her discharge. In another case, VOPA represented a person who was found Not Guilty of a misdemeanor by Reason of Insanity. VOPA advocated for his release after 9 years in forensic custody. VOPA worked collaboratively with his criminal attorney to ensure that an appropriate discharge plan was put in place and that the Court accepted it. The person is now living successfully in the community.

After one year in a State mental health institution and several months before that in a private psychiatric facility, VOPA learned of a woman who had been designated Ready-For-Discharge for six months. She expressed significant concerns over the speed of the discharge process. She believed her discharge was delayed due to a lack of effort from her destination Community Services Board (CSB). She stated that the placement facility her discharge plan identified had not changed since her entrance into the State institution although her condition, treatment and community support had changed significantly in the interim. She expressed much frustration over this, and dissatisfaction with her CSB. She also seemed to lack critical information necessary to her involvement in the discharge planning process.

The institution staff stated that the delays in her discharge resulted from her record involving criminal activity and med-noncompliance and she had not agreed to the placement facility. The records indicated that only two facilities had been identified for her placement since her entrance into the State institution. She had visited both facilities several times and continually expressed serious concerns over her future treatment and safety in each facility. It appeared the discharge delay was due to a the lack of communication between the CSB case manager and the client, and a lack of understanding of the client's preferences and concerns on the part of the CSB case manager.

VOPA involvement in this matter consisted of discussion with the CSB, the client and the hospital treatment team regarding their versions of the process to date, and how each understood the final goal. In addition, VOPA contacted the facilities identified in the discharge plan as well as other facilities within the region. VOPA offered an evaluation of the process and suggestions for future action. Within ten days of VOPA's initial involvement, the client achieved discharge and placement in an agreeable facility. She has since left that facility of her own accord and lives independently in the community with the support of her family. She continues to receive treatment and began a new job in September. Here, VOPA identified an issue unknown to the players and served as a conduit of necessary information to significantly speed up the discharge process.

VOPA had an active role in ensuring that persons who have been found incompetent to stand trial are admitted to State mental health institutions rather than kept in jails. VOPA identified several such clients and contacted their attorneys. There has been a decrease in the waiting time for persons to be admitted to mental health institutions from jails. In addition, VOPA represented two persons with mental illness who were found Not Guilty by Reason of Insanity of misdemeanors. Both persons should have been released from State mental health institutions but the judges presiding over their cases have refused to do so. VOPA worked in conjunction with their criminal attorneys to ensure that they were released. In one case, VOPA drafted a Motion to require the Judge to allow the person to be released. Prior to the Motion being filed, the individual was discharged to the community.

Goal 4: People with Disabilities Live in the Most Integrated Environment Possible

Focus Area #3: Appropriate Staffing at State Residential Facilities
Objective #1: In each investigation of abuse and neglect, establish whether staffing may have contributed to the abuse or neglect and take appropriate action

For each indicator of success, provide the following information:

a. Focus #3 Objective #1
b. Objective was: Met
c. Base Measure used to determine whether priority was met: A base measure was not established as the effort is contingent upon the content of the reports received
d. Target population: PAIMI eligible individuals residing in State mental health institutions
e. Outcome: systemic reform

Staffing is addressed and considered in all State institution investigations. VOPA continues to conduct quarterly trend analyses to determine whether higher incidents of reported injuries are related to staffing levels. In one investigation, VOPA identified significant failures with regard to the qualification of medical personnel to provide appropriate primary care services. The institution has agreed to require that staff psychiatrists receive continuing education in primary care. This systemic reform had the potential to impact a census of about 140 patients.

In another investigation, VOPA found that inadequate staffing procedures for replacement or supplemental nursing staff contributed to abuse or neglect of a patient. A formal administrative complaint was filed and successfully resolved.

Goal 4: People with Disabilities Live in the Most Integrated Environment Possible

Focus Area #3: Appropriate staffing at State Residential Facilities
Objective #2: Investigate staffing at Eastern State Hospital for compliance with applicable federal requirements. If non-compliance is found, take action to effect change.

For each indicator of success, provide the following information:

a. Focus #3 Objective #2
b. Objective was: Met
c. Base Measure used to determine whether priority was met: investigation complete
d. Target population: PAIMI eligible individuals residing in State mental health institutions
e. Outcome: systemic reform

VOPA's investigation of a death at Eastern State Hospital revealed numerous instances of abuse and neglect relating to the administration of psychotropic medication, monitoring of the individual while in seclusion, and staffing. VOPA filed a formal complaint and plan for corrective action and conducted the required complaint resolution meeting with the hospital director. The director's final decision and action plan set forth changes that the hospital will make in policy and procedure and a schedule for staff training. VOPA is monitoring compliance with corrective action plan. The hospital has provided training records to document the completion of staff training. This systemic reform favorably affects an average census of 400 patients.

Goal 4: People with Disabilities Live in the Most Integrated Environment Possible

Focus Area #3: Appropriate staffing at State Residential Facilities
Objective #3: Conduct quarterly trend analyses to determine whether a higher number of incidents of reported injuries are related to staffing levels.

For each indicator of success, provide the following information:

a. Focus #3 Objective #3
b. Objective was: Met
c. Base Measure used to determine whether priority was met: quarterly trend analyses
d. Target population: patients of mental health institutions in Virginia who experienced an injury that rose to the level of CIR
e. Outcome: quarterly trend analyses conducted

VOPA conducts quarterly trend analyses of critical incident reports received from State mental health institutions. The trend analyses address a wide variety of potential trends, including type of injury, location of injury, time of day and day of the week, staffing, and other areas. Trend analyses are continuing and are being refined to account for variations, including the number of patients in one institution compared to the number in another institution, and other potential variables to assure accurate comparisons of trends between the various institutions. The VOPA Executive Director conducts a weekly meeting with VOPA staff to discuss and strategize about the reports and their implications. The quarterly trend analyses are planned and conducted per those meetings.

Goal 5: People with Disabilities are Employed to their Maximum Potential

Focus Area #1: Supported employment
Objective #1: Provide legal representation for fifteen (15) persons with disabilities to ensure that they receive appropriate employment training, as a part of their transition planning from school to post-school activities that meets their abilities, needs, and preferences.

For each indicator of success, provide the following information:

a. Focus #1 Objective #1
b. Objective was: Met
c. Base Measure used to determine whether priority was met: 15 persons with disabilities--this objective was designed to serve persons with any disability; not just PAIMI eligible individuals.
d. Target population: individuals who need appropriate employment training as part of their special education transition services
e. Outcome: clients' needs in this area were met

VOPA has represented persons who complained that the Department of Rehabilitative Services failed to provide adequate transition planning and assistance. VOPA has also acquired and is reviewing contracts between school districts and DRS setting forth each entity's responsibility to provide transition planning. VOPA is currently investigating whether the Disability Service Agencies meet their obligation to take an active role in transition planning. VOPA found that DRS was refusing to provide transition services to eligible children until their last year of high school. After determining that DRS did not provide adequate transition serves, VOPA served a Notice of Potential Litigation on its Commissioner. VOPA demanded that DRS provide transition services to eligible children regardless of their age. Settlement negotiations are ongoing.

Goal 5: People with Disabilities are Employed to their Maximum Potential

Focus Area #1: Supported Employment
Objective #2: Represent ten (10) persons with disabilities who have disputes with the Department of Rehabilitative Services regarding supported employment

For each indicator of success, provide the following information:

a. Focus #1 Objective #2
b. Objective was: Met
c. Base Measure used to determine whether priority was met: 10 persons with disabilities--this objective was designed to serve persons with any disability; not just PAIMI eligible individuals.
d. Target population: individuals having disputes with the Department of Rehabilitative Services about supported employment
e. Outcome: clients' needs were met

VOPA represented over ten people with disabilities who were denied needed supports and services to gain or maintain employment. In all cases, VOPA advocates for its clients to receive appropriate supported employment services, including vocational rehabilitation and rehabilitation counseling. In one case, VOPA represented a woman with mental illness who was having difficulty working with the Department of Rehabilitative Services to formulate an Individual Plan for Employment. VOPA is working with the client and advocating for her to receive an appropriate IPE.

Goal 6: People with Disabilities have Equal Access to Appropriate and Necessary Health Care

Focus Area #1: Access to Psychiatric Medications in County and Municipal Jails
Objective #1: Represent three (3) inmates in county or municipal jails who have been denied access to needed psychiatric medications.

For each indicator of success, provide the following information:

a. Focus #1 Objective #1
b. Objective was: Met
c. Base Measure used to determine whether priority was met: 3 inmates
d. Target population: PAIMI eligible individuals in county or municipal jails
e. Outcome: clients' needs were met

VOPA has represented four inmates in county or municipal jails who have been denied access to needed psychiatric medications. In one case, an inmate's day-to-day living and potential release were compromised due to the jail's failure to provide medications during the incarceration and failure to provide an adequate supply of such medications for sue after release from custody, placing the inmate at significant risk. VOPA resolved all issues by advocacy and coordination between service providers and law enforcement authorities.

Besides the four open cases, VOPA's advocacy directly resulted in ten additional inmates receiving needed psychiatric medications and services and includes, as appropriate, transfer from jail to a State mental health institution for treatment.

Goal 7: People with Disabilities in the Commonwealth of Virginia are Aware of VOPA's Services

Focus Area #1: Underserved Communities
Objective #1: By December 2003, identify one (1) additional target population to receive outreach and training
Objective #2: Create training materials and a presentation for the target population by March 31, 2004
Objective 3: Complete mailings and at least two (2) presentation to the target population by September 2004

For each indicator of success, provide the following information:

a. Focus #1 Objective # 1, 2, 3
b. Objective was: Not Met
c. Base Measure used to determine whether priority was met: 1 target population
d. Target population: underserved disability population
e. Outcome : Objectives have been revised and continued

The VOPA client database was going to play an integral component in identifying an underserved population. However, VOPA discovered that the database had significant integrity issues. VOPA staff have spent a significant amount of time and effort to develop and implement database enhancements that will help in the identification of underserved populations. These objectives have been carried over to FY2005.

Goal 7: People with Disabilities in the Commonwealth of Virginia are Aware of VOPA's Services

Focus Area #1: Underserved Communities
Objective #4: Conduct quarterly trainings for McGuire Veterans Administration Medical Center residents.

For each indicator of success, provide the following information:

a. Focus #1 Objective #4
b. Objective was: Met
c. Base Measure used to determine whether priority was met: quarterly trainings
d. Target population: PAIMI eligible individuals residing in McGuire Veterans Administration Medical Center
e. Outcome: patients have received disability rights information

VOPA staff conducted quarterly trainings for patients at the Department of Veterans Affairs McGuire Hospital quarterly. Although the hospital is aware that VOPA is to provide these trainings due to the Federal Court settlement, routine scheduling of the trainings is an on-going challenge. In addition, free access to the patients is hampered by McGuire staff escorting VOPA staff throughout the wards. The McGuire staff portray a protective, and somewhat paternalistic, approach about the patients in their interactions with VOPA.

Annual staff training has been provided to the McGuire staff about disability rights. The participants have included varying levels staff providers. Future staff trainings will include information on self determination, choice, and informed consent.

Because of the historical settlement VOPA achieved in FY2003 with the Department of Veterans Affairs, there has been nation-wide interest in VOPA's work in this area. The National Association of Protection and Advocacy Systems (NAPAS) faxed a copy of the settlement to every protection and advocacy system legal director. They also noted VOPA's achievement in their newsletter for their Training and Advocacy Support Center (TASC). NAPAS has been in contact with the Department of Veterans Affairs to discuss the possibility of the agency adopting a similar access policy nationwide for protection and advocacy entities. (Please see attachment.)

Goal 7: People with Disabilities in the Commonwealth of Virginia are Aware of VOPA's Services

Focus Area #3: Juvenile Detention Facilities
Objective #1: Provide VOPA information to Juvenile Probation Officers and Court Appointed Special Advocates.

For each indicator of success, provide the following information:

a. Focus #2 Objective #1
b. Objective was: Met
c. Base Measure used to determine whether priority was met: 1 mailing
d. Target population: PAIMI eligible individuals served by the Juvenile Probation Officers and Court Appointed Special Advocates
e. Outcome: mailing recipients received information about disability rights

A mailing to juvenile facilities and Court Appointed Special Advocates, including clarification of VOPA's right to access, was completed.

Goal 7: People with Disabilities in the Commonwealth of Virginia are Aware of VOPA's Services

Focus Area #2: Spanish-Speaking Constituents
Objective #1: Identify five (5) Spanish community contacts in Virginia by December 2003

For each indicator of success, provide the following information:

a. Focus #2 Objective #1
b. Objective was: Met
c. Base Measure used to determine whether priority was met: 5 contacts
d. Target population: PAIMI eligible individuals who speak Spanish
e. Outcome: minority community received information about disability rights

VOPA has partnered with the Governor's Latino Advisory Commission Liaison to develop a planful, strategic outreach effort. VOPA is developing and nurturing a representative committee that reflects the disability and Spanish Speaking communities to help in this area. We have invited representatives from the VOPA Advisory Councils to join this effort.

Goal 7: People with Disabilities in the Commonwealth of Virginia are Aware of VOPA's Services

Focus Area #2: Spanish-Speaking Constituents
Objective #2: Develop two (2) VOPA primary publications in Spanish by June 2004

For each indicator of success, provide the following information:

a. Focus #2 Objective #2
b. Objective was: Partially Met/Continuing
c. Base Measure used to determine whether priority was met: 2 publications
d. Target population: PAIMI eligible individuals who speak Spanish
e. Outcome- objective is continuing

VOPA's main publication was revised this year (it was included in the PAIMI application). This publication was translated into Spanish using a software package. To ensure that the translation had retained the intent and tone of the English version, VOPA had a person who speaks Spanish review it. It was then shared with VOPA's Spanish Speaking Outreach Committee who recommended further edits.

VOPA intended to translate its poster into Spanish. However, public comment this year has alerted us that many people cannot distinguish the difference between VOPA and the DMHMRSAS Human Rights poster. DMHMRSAS' poster is currently under revision. Once they complete their poster, VOPA will review our poster for revision/translation.

Goal 7: People with Disabilities in the Commonwealth of Virginia are Aware of VOPA's Services

Focus Area #2: Spanish-Speaking Constituents
Objective #3: Complete two (2) presentations or training sessions between June 2004 and September 2004 for Spanish communities.

For each indicator of success, provide the following information:

a. Focus #2 Objective #3
b. Objective was: Met
c. Base Measure used to determine whether priority was met: 2 presentations
d. Target population: PAIMI eligible individuals who speak Spanish
e. Outcome: minority community received information about disability rights

A presentation was provided to the Governor's Latino Advisory Commission about VOPA and disability rights. Based on feedback from the Commission, VOPA has re-evaluated and revised its outreach plan for this population. At the first meeting of the potential Spanish Speaking Outreach committee, a discussion about VOPA's mission and disability rights was conducted.

Goal 7: People with Disabilities in the Commonwealth of Virginia are Aware of VOPA's Services
Focus Area #3: Adult Care Homes (Assisted Living Facilities) Objective #1: Inform operators and residents of VOPA's mission and availability by completing a mailing of VOPA posters and materials by December 2003.
For each indicator of success, provide the following information: a. Focus #3 Objective #1 b. Objective was: Met c. Base Measure used to determine whether priority was met: 1 mailing to 56 providers d. Target population: PAIMI eligible residents of adult care homes/assisted living facilities e. Outcome: mailing targeted population received information about disability rights
A mailing list targeting Virginia Department of Social Services licensed assisted living facilities in southwest Virginia was completed. This mailing including VOPA brochures, posters and a cover letter informing them of VOPA's mission and availability.

Goal 7: People with Disabilities in the Commonwealth of Virginia are Aware of VOPA's Services
Focus Area #3: Adult Care Homes (Assisted Living Facilities) Objective #2: Inform operators of VOPA's availability to provide training in the area of disability rights through random monthly drop-in visits.
For each indicator of success, provide the following information: a. Focus #3 Objective #2 b. Objective was: Met c. Base Measure used to determine whether priority was met: 12 drop in visits d. Target population: PAIMI eligible residents of adult care homes/assisted living facilities e. Outcome: Adult Care Homes monitored received information about disability rights
VOPA has developed a monitoring protocol for drop-in visits to Adult Care Homes. Feedback is provided to the Adult Care Homes about their efforts to protect disability rights.

SECTION III. INDIVIDUAL PAIMI CLIENTS
A. Number of Individual Clients Served with PAIMI Funds.
1. Total of PAIMI-eligible clients who were receiving advocacy at start of fiscal year. 37
2. Total of new/renewed PAIMI-eligible clients served during the fiscal year. 73
3. Total of PAIMI-eligible individuals served in A.1. and A. 2. 110

4. The number of PAIMI-eligible individuals who requested individual advocacy services under the PAIMI Act [42 U.S.C. 10801 et seq.] and were not 'served' within 30 days of initial contact either due to insufficient PAIMI funding or non-priority issues, include individuals who received other services such as information and referral in-lieu): 2084

5. Identify populations, advocacy issues and activities (systemic, legislative, educational, training, etc.) that will be addressed in the future:

VOPA is establishing its identity as an independent State agency that provides protection and advocacy services for individuals with disabilities. The Governing Board of Directors, the PAIMI Advisory Council, and staff have learned the opportunities and challenges this affords VOPA. The organizational re-structuring and physical move of the Office has begun the process of exercising this independent "identity."

VOPA's objectives for FY05 include more systemic, collaborative and policy work in the areas of abuse/neglect and community integration.

In addition, VOPA is establishing a more planful, strategic outreach effort for underserved and unserved populations.

B. Number of Case Problems of Individual PAIMI-Eligible Clients 134

C. Age of Individual Clients [See, 42 U.S.C. 10804(a)(1)(4), 42 CFR 51.24 (a)]

0-4: 0	5-12: 1	13-18: 11	19-25: 9	26-64: 86	65+: 3	Total: 110

D. Gender of Individual Clients

Male: 63	**Female:** 47	**Total:** 110

E. Ethnicity/Racial Background of Individual Clients

a. American Indian or Alaska Native	1
b. Asian	1
c. Black or African American	26
d. Hispanic/Latino	4
e. Native Hawaiian or Other Pacific Islander	
f. White	78
Total	110

F. Clients' Living Arrangements at Intake			Total
Independent			6
Parental or other Family Home			5
Community Residential Home for Children/Youth (0- 18 years) (e. g., supervised apartment, semi-independent, halfway house, board & care, small group home 3 or less)			
Adult Community Residential Home (e. g., supervised apartment, semi-independent, halfway house, board & care, small group home 3 or less)			4
*Non-medical community-based residential facility for children & youth (Age 0-18)			
Foster Care			
*Nursing Facilities, including Skilled Nursing Facilities(SNF)			
*Intermediate Care Facilities (ICF)			
* Public and Private General Hospitals, including emergency rooms			
* Other health facility			
Psychiatric wards (public or private)			
Public (Municipal or State-operated) Institutional Living Arrangement (e.g., hospital treatment center/school or large group home 4+ beds)			76
Private Institutional Living Arrangement (e.g., hospital or treatment center, school or large group home more than 3 beds)			5
Legal Detention/Jail/Detention Center			9
State Prison			4
Homeless			1
Federal Facility (List)	1. Detention	2. Prison	
3. Veterans Hospital	4. Military	5. Other (describe)	
Total Client Cases by Living Arrangement			110

SECTION IV. CASE COMPLAINTS/PROBLEMS OF INDIVIDUAL CLIENTS

A.1. Alleged Abuse: Number of Complaints/problems

Areas of Alleged Abuse	Outcomes	# from Closed Cases Only
a. Inappropriate or excessive medication	A=2, B=1, D=1, E=7	11
b. *Inappropriate or excessive: 1. Physical restraint,	B=2, E=2	4
2. Chemical restraint		
3. Mechanical restraint	A=1, D=2, E=3	6
4. Seclusion		
c. Involuntary medication	A=5, B=2, D=2, E=7	16
d. Involuntary Electrical Convulsive Therapy (ECT)		
e. Involuntary aversive behavioral therapy		
f. Involuntary sterilization		
g. Failure to provide appropriate mental health treatment	A=12, B=3, C=9, D=8, E=8	40
h. Failure to provide needed or appropriate treatment for other serious medical problems	C=2, E=1	3
i. *Physical assault: 1) Serious injuries related to the use of seclusion and restraint.	A=1, B=2, C=2, D=1, E=5	11
2) Serious injuries NOT related to seclusion and restraint.		
j. Sexual assault	C=3, E=2	5
k. Threats of retaliation or verbal abuse by facility staff	A=1, B=2, D=1, E=2	6
l. Coercion		
m. Financial exploitation		
n. Other. **Please describe on a separate sheet. This number should be less than 1% of the total # of abuse complaints. Make every effort to report within the above categories.		
TOTAL (Sum of a. - n.)	A=22, B=12, C=16, D=15, E=37	102

A. 2. Complaints Disposition: For closed cases, provide the numbers of abuse complaints/ problems for each disposition category.

a. # of Complaints/Problems Determined Not to Have Merit on Investigation	9
b. # of Complaints/Problems Withdrawn or Terminated by Client	7
c. # of Complaints/Problem Favorably Resolved in Client's Favor	86
d. # of Complaints/Problem Not Favorably Resolved in Client's Favor	
e. Total Number of Complaints/Problem Addressed From Closed Cases	102

[Items a- e must equal the Total # of Complaints in Section IV. A.1.)

A.3. Abuse Outcome Statements

For each area of alleged abuse, choose one or more outcome statements that best describe or relate to the complaint/problem area. Enter the appropriate letter(s) in the "outcome" column in the above table.

A. Persons with disabilities whose environment was changed to increase safety or welfare

B. Positive changes in policy, law or regulation re: abuse in facilities (describe facility where impact was made)

C. Investigations of abuse by the P&A

D. Validated abuse complaints that have favorable resolution as a result of P&A intervention

E. Other indicators of success or outcomes: no outcome to report; client received information about rights and strategies and facilitated the client's ability to pursue enforcement of their rights

B. 1. Alleged Neglect : Number of Complaints/Problems: Failure to Provide For Appropriate.

Areas of Alleged Neglect	Outcomes	# From Closed Cases Only
a. Admission to residential care or treatment facility		
b. Transportation to/from residential care or treatment facility		
c. Discharge planning or release from a residential care or treatment facility	A=14, E=15	29
d. Mental health diagnostic or other evaluation (does not include treatment)		
e. Medical (non-mental health related) diagnostic or physical examination		
f. Personal care (e.g., personal hygiene, clothing, food, shelter)		
g. Physical plant or environmental safety		
h. Personal safety (client-to-client abuse)	A=2, E=8	10
i. Written treatment plan	A=1, E=1	2
j. Rehabilitation/vocational programming		
l. Other. [Please describe. However, make every effort to report within the above categories.		
TOTAL (Sum of a-j)	A=2, E=24	41

B. 2. Complaints Disposition: For closed cases, provide the numbers of neglect complaints or problem areas for each disposition category. [See, 42 U.S.C. 10802(5)]

a. # of Complaints/Problems Determined Not to Have Merit on Investigation	6
b. # of Complaints/Problems Withdrawn or Terminated by Client	3
c. # of Complaints/Problem Favorably Resolved in Client's Favor	32
d. # of Complaints/Problem Not Favorably Resolved in Client's Favor	
e. Total Number of Complaints/Problem Addressed From Closed Cases	41

[Sum of a-d. must equal the total of complaints listed in Section IV. B.1.]

B.3. Neglect Outcome Statement

For each area of alleged neglect, choose one or more outcome statements that either best described or related to the complaint/problem. Enter the appropriate letter(s) in the "outcome" column in table - B.1.

A. Investigations of neglect with P&A involvement.
B. Validated incidents of neglect by type.
C. Positive changes in policy, law or regulation regarding neglect in facilities (describe facilities).
D. Persons with disabilities discharged consistent with their treatment plan after P&A involvement.
E. Persons with disabilities whose treatment plans met selected criteria.
F. Other indicators of success or outcomes that resulted from P*+&A involvement (explain)

C.1 Alleged Violations of Rights: **Number of Complaints/problems on Rights Protection:**

Areas of Alleged Rights Violations	Outcome	Complaints from Closed Cases Only
a. Housing Discrimination		
b. Employment Discrimination		
c. Denial of financial benefits/ entitlements (e.g., SSI, SSDI, Insurance)		
d. Guardianship/Conservatorship problems	D=2	2
e. Denial of rights protection information or legal assistance	C=4, D=12	16
f. Denial of privacy rights (e.g., congregation, telephone calls, receiving mail)		
g. Denial of recreational opportunities (e.g., grounds access, television, smoking)		
h. Denial of visitors		
I. Denial of access to or correction of records		
j. Breach of confidentiality of records (e.g., failure to obtain consent before disclosure)	D=4	4
k. Failure to obtain informed consent (see also, involuntary treatment)	D=4	4
l. Failure to provide education (consistent with IDEA and state requirements)	D=3	3

Areas of Alleged Rights Violations	Outcome	Complaints from Closed Cases Only
m. Advance directives issues		
n. Denial of parental/family rights		
o. Consumer financial issues		
p. Immigration issues	D=2	2
q. Criminal justice issues	C=1, D=4	4
r. Denial of community habilitation services		
s. Health insurance/managed care issues		
t. Other. [Please describe separately. Make every effort to report within the above categories.]		
TOTAL (Sum of a. - t.)	C=5, D=30	35

See, PAIMI Act 42 U.S.C. 10801(b)(2)(A)

C. 2. Complaints Disposition: For closed cases, provide the numbers of civil rights complaints or problem areas for each disposition category.

a. # of Complaints/Problems Determined Not to Have Merit on Investigation	2
b. # of Complaints/Problems Withdrawn or Terminated by Client	
c. # of Complaints/Problem Favorably Resolved in Client's Favor	33
d. # of Complaints/Problem Not Favorably Resolved in Client's Favor	
e. Total Number of Complaints/Problem Addressed From Closed Cases	35

[Items a-d should equal the Total # of Complaints listed above in Table C.1]

C.3. Violations of Rights Outcome Statements

For each of the areas of alleged violation of rights, choose one or more outcome statements that best describes or is related to the complaint/problem area. Enter the appropriate letter(s) in the "outcome" column in the table above.

A. Persons with disabilities served by the P&A who's 'rights' were restored as a result of P&A Intervention.

B. Persons with disabilities whose personal decision making was maintained or expanded as a result of P&A intervention.

C. Policies or laws changed and other barriers to personal decisions making eliminated as a result of P&A intervention.
D. Other outcomes as a result of P&A involvement : quality of life improvement; P&A involvement substantiated client's complaint

D. Intervention Strategies to Address Individual Clients Complaints/Problems Areas: Enter the number of intervention strategies used to address each client complaint/problem area. A client may have more than one complaint and each complaint may require more than one intervention strategy. The total number of intervention strategies may exceed the total number of clients served. **[Do not report each phone call, letter, meeting, or other action taken on behalf of a client as a separate intervention strategy. Referrals, counseling, and negotiation are considered cumulative processes**]. See Glossary for the definitions of "Intervention Strategies. [See the PAIMI Act 42 U.S.C. 10805(a)(1)(B), 42 U.S.C. 10807 (a),(b) and the PAIMI Rules 42 CFR at 51.31 (a)]

Intervention Strategies	**Outcome**	**Number**
1. Short Term Assistance:		11
2. Abuse/Neglect Investigations:		23
3. Technical Assistance:		16
4. Administrative Remedies:		7
5. Negotiation/Mediation:		25
6. Legal Remedies:		
Total Invention Strategies [Add items 1-6.]		82

VOPA does not collect outcomes on individual intervention strategies. Instead, we identify the highest level of intervention and determine an outcome for that strategy.

E. Death Investigation Activities. See, the PAIMI Act 42 U.S.C. at 10801(b)(2)(B) and 10802(1), and PAIMI Program expanded authorities under the Children's Health Act of 2000, Part H, section 592(a) and Part I Section 595, as codified respectively under Title V. Public Health Service Act, 42 U.S.C. at 290ii- 290ii and 290jj-1 - 290jj-2].

1. All deaths of PAIMI-eligible individuals reported to the P&A for investigation.
A. The State operated mental health institutions 56
B. The Center for Medicaid & Medicare Services (Regional Offices) 0*
C. Other (describe) 0
D. **Total** 56

*VOPA has contacted by letter all known psychiatric residential treatment facilities in the State of Virginia and alerted them of the requirement to report deaths to VOPA. There has been inconsistent response to this. In FY05, VOPA will take a more assertive approach in ensuring this reporting happens.

It should be noted that although deaths are reported to VOPA, not all of them are investigated. For example, of the 56 reported deaths above from State operated mental health institutions, 41 were of geriatric patients who may have died of natural causes. VOPA uses the CIR process to determine which death reports it will open for full investigations.

2. All P&A death investigations conducted involving PAIMI-eligible individuals related to.

A. Seclusion 1
B. Restraint 0
C. Total 4

3. **Describe P&A involvement**:

Four death investigations have been conducted. Three have been completed with recommendations to the institution.

One investigation revealed significant failure by the institution to conduct essential medical tests and failure to provide needed services by primary care physicians. VOPA found that both failures contributed to a patient's death, caused by gangrene infection, and constituted abuse or neglect. As a result of the investigative findings, VOPA recommended substantial systemic corrective action, including mandatory, annual primary care medical training for facility psychiatrists and mandatory and specific follow-up of abnormal laboratory test results. All recommendations have been accepted by the institution and implemented.

Another investigation uncovered numerous instances of medication without informed consent, inadequate staffing and failure to conduct required monitoring while a patient was secluded. A formal administrative complaint was filed and the facility has agreed to needed systemic reforms.

SECTION V. INTERVENTIONS on BEHALF of GROUPS of PAIMI-ELIGIBLE INDIVIDUALS

A. Types of Interventions - Summary of Information. The following table captures information on how the P&A program used PAIMI Program funding, including program income, to support non-individual client activities.. This information is not reflected in previous sections of this report. In this table, report all annual program priorities activities for this fiscal reporting period. The items listed in the table's left column and the numbers reported for each category should relate to the narrative section that follows.

Type of Invention	Potential # of Individuals Impacted	Concluded Successfully	Concluded Unsuccess-fully	On-going
Group Advocacy non-litigation: Assisted Living Facility Outreach Project: mailing +12 site visits	About 1800 residents	X		Expanded for FY05
Group Advocacy non-litigation: Mental Health Needs Survey	Nearly 500,000* Virginians w/ MH issues			X
Legislative & Regulatory Advocacy: General Assembly-guardianship pursuit for CSB service recipients-House Bill 984	Over 100,000*	X		General Assembly meets annually
Legislative & Regulatory Advocacy: General Assembly-Office of Inspector General-Senate Bill 212	About 1600**	X		General Assembly meets annually
Total	603,400			

(*estimate developed based on data in DMHMRSAS State Plan 12/03)
(estimate based on averaging monthly census numbers provided by DMHMRSAS)

Group Advocacy non-litigation: Assisted Living Facility Outreach Project: mailing +12 site visits

VOPA conducted a mailing to assisted living facilities (ALF) in the southwestern area of Virginia. Fifty-six (56) Department of Social Services licensed assisted living facilities received the mailing that included a cover letter noting the P&A's authority to access the facilities, notification of the State requirement that they display our toll-free number, some VOPA posters with the number, and notification of VOPA's availability for consultation and training about disability rights. These facilities have a bed capacity of 1698 (they may not all be full; nor are they all PAIMI eligible individuals).

VOPA developed a protocol for visiting the ALFs monthly. Sites were selected to ensure statewide coverage.

Group Advocacy non-litigation: Mental Health Needs Survey

VOPA contracted with Virginia Commonwealth University's School of Social Work to conduct a study of the needs of individuals with mental illness. The study examines the needs of four special populations within the mentally ill community: needs of individuals who are homeless and mentally ill; needs of children with mental illness; needs of incarcerated individuals with mental illness; and needs of individuals receiving inpatient psychiatric treatment. The research

project includes telephone interviews, face-to-face interviews and mailed surveys. In addition to providing the funding for the project, VOPA staff are also involved in ensuring the rights of institutionalized individuals to participate in the project. We expect a finished project in Spring 2005.

Legislative & Regulatory Advocacy: HB 984-General Assembly-guardianship pursuit for CSB service recipients

The initial bill was designed to modify the definitions of "conservator" and "guardian" to include any local or regional tax-exempt charitable organization that is established to provide conservatorial or guardian services to incapacitated persons. VOPA collaborated with the Virginia Association of Community Services Boards (the local public provider of mental health, mental retardation and substance abuse services), the Virginia Department of Aging and the Office of Human Rights in the Department of Mental Health, Mental Retardation and Substance Abuse Services (DMHMRSAS) to educate policy makers about the bill's ability to create a potential conflict of interest. The final language of the bill read: *Such tax-exempt charitable organization shall not be a provider of direct services to the incapacitated person.*

Legislative & Regulatory Advocacy: SB 212-General Assembly-Office of Inspector General for DMHMRSAS

This bill describes the powers and duties of the Inspector General and clarifies that the Inspector General can access information related to the delivery of services to consumers operated by the Department of Mental Health, Mental Retardation and Substance Abuse Services or served by providers outside of the State institutional system, including the licensed mental health treatment units in state correctional facilities. In collaboration with the bill's patron, Legislative Services, the Inspector General's Office and the Mental Health Association, VOPA educated policy makers on the need for the Inspector General's Office to be allowed to make "unannounced" visits to providers.

C. **Outcome Statement**

For each area of non-client advocacy activity, choose one or more outcome statements that either best described or related to the complaint/problem. Enter the appropriate letter(s) in the "outcome" column above.

A. Persons who received information about the P&A and its services

B. Persons with disabilities (or their family members) who received education or training about their rights, enabling them to be more effective self advocates.

C. Other outcomes that resulted from PAIMI Program involvement

SECTION VI. NON-CLIENT DIRECTED ADVOCACY ACTIVITIES

A. Individual Information and Referral (I & R) Services:	
Provide total number of I&R services.	**Total:** 4036

B. State Mental Health Planning Activities

Virginia's Mental Health Planning Council represents consumer, family, and advocacy interests. The Council advocates for a more responsive service system and assists in the monitoring, implementation and oversight of service system objectives of Virginia's Mental Health Plan. Council members advocate for the continuing development and expansion of a comprehensive community-based service system for Virginia's priority mental health populations -- adults with a serious mental illness, children and adolescents with a serious emotional disturbance, and children at risk of developing a serious emotional disturbance. In the past year, the Council's goals and activities have included:

- Educating Virginians about the need for children's services;
- Promoting recovery and recovery services for adults with mental illness by supporting programs such as Consumer Empowerment Leadership Training (CELT); and
- Monitoring funding for and restrictions on medications provided by the Sstate pharmacy, Medicaid and other sources.

In addition, VOPA staff participated in the DMHMRSAS Advisory Council for Services to People Who Are Deaf, Hard of Hearing, Late Deafened and Deaf-Blind. Their mission is to provide the DMHMRSAS support, consultation, and technical assistance regarding comprehensive mental health, mental retardation, and substance abuse services for persons who are deaf, hard of hearing, late deafened, or deafblind. Meetings were held quarterly.

C. Education, Public Awareness Activities and/or Events.	
1. Number of Education/Training Activities Undertaken	**Total:** 38
2. Total number of persons trained (approximate)	**Total:** 987

SECTION VI. NON-CLIENT DIRECTED ADVOCACY ACTIVITIES

3. Dissemination Activities	**# of Items* or events**	****Estimated # of persons receiving the information**	**Outcomes**
a. Radio/TV appearances			
b. Newspaper articles (attach articles)	17	Over 585,200 readers	A, B, C
c. PSAs/videos/films/, etc.			
d. Reports			
e. Publications, including articles in Professional journals	40 mailings	4193	A, B, C
f. Other P&A disseminated information, including general training, outreach or presentations not included counted under training activities).			
g. Number Website hits	15,178	15,178	A, B, C
h. Describe other media activities Local TV station coverage of VOPA investigation-Brice's Villa	1	42,104	A, C
Total:	15236	646,675	A, B, C

SECTION VII. GRIEVANCE PROCEDURES [42 CFR Section 51.25]

1. The number of grievances filed by PAIMI-eligible clients, including representatives or family-members of such individuals receiving services during this fiscal year. **Total** 1			
2. The number of grievances filed by prospective PAIMI-eligible clients (those who were not served due to limited PAIMI program resources or because of non-priority issues. **Total** 2			
3. Total [Add 1 & 2] 3 **[42 CFR Section 51.25(a)(1),(2)]**			
4. The number of grievances appealed to: **[42 CFR 51.25(b)(1)]**			
a. The governing authority	**Total:** 0	b. The Executive Director	**Total:** 0
c. Total 4a. and 4b. 0			
5. Number of reports sent to the governing board **AND** the Advisory Board (at least one annually) that describe the grievances received, processed, and resolved. **Total:** 1 each			
6. Below, please identify all individuals, by name & title, responsible for grievance reviews. Gary Conover, Managing Attorney Jonathan Martinis, Managing Attorney Colleen Miller, Executive Director The Governing Board establishes an ad hoc Grievance Committee that is called as needed.			
7. What is the timetable (in days) used to ensure prompt notification of the grievance procedure process to clients, prospective clients or persons denied representation, and ensure prompt resolution. 21 **[42 CFR 51.25(b)(4)]**			
8. Were written responses sent to all grievants? Yes			
9. Was client confidentiality protected? Yes			

SECTION VIII. OTHER SERVICES AND ACTIVITIES

A. List groups (e.g., States, consumer, advocacy, service providers, professional organizations and others, including groups of current and former mental health consumers and/ or family members of such individuals) **with whom the PAIMI Program coordinated systems, activities, and mechanisms.**

Department of Mental Health, Mental Retardation and Substance Abuse Services and institutions
Local Human Rights Committees
Mental Health Planning Council
National Alliance for the Mentally Ill-Virginia and local affiliates
Partnership for People with Disabilities
Virginia State Independent Living Council
Department of Rehabilitative Services
Department of Medical Assistance Services
Office of the Attorney General
Advisory Council for Services to the Deaf, Hard of Hearing DeafBlind and Late-Deafened
Virginia Public Guardian and Conservator Advisory Board
Virginia Board for People with Disabilities
State Special Education Advisory Council
Virginia Workforce Council
Office of the Inspector General
Virginia Interagency Coordinating Council
Medicaid Buy-In Work Group
Centers for Independent Living
Virginia Commonwealth University
Community Services Boards

Note: this list is not meant to be all-inclusive.

B. Provide a *brief* description of the outreach efforts/activities used to increase the numbers of minority clients served and/or educated about the PAIMI Program.

VOPA has partnered with the Governor's Latino Advisory Commission Liaison to develop a planful, strategic outreach effort for Virginians with disabilities who speak Spanish. VOPA is developing and nurturing a representative committee that reflects the disability and Spanish speaking communities to help in this area. We have invited representatives from the VOPA Advisory Councils to join us. In addition, our Resource Advocacy Unit, which handles all requests for services has practiced with the telephone "Language Line". This is to ensure that if we get calls from minority callers that they can be handled efficiently. We are also working on having publications translated into Spanish.

VOPA maintains a website that posts all of our Federal grants' goals and objectives. This website also has the notices for the Board of Directors' and VOPA's Advisory Councils meetings. Job vacancies, announcements, VOPA publications, quarterly newsletters, and

disability-related links are also available. The annual public comment process is posted on the website and visitors can participate on-line

Please see the chart below for a comparison of the Virginia population and the VOPA clients served in FY04. VOPA is sensitive to the need to explore more and better means of conducting outreach for minorities in all areas of our programs

Demographic Stats-Estimates
VOPA Clients and Virginia Population

Ethnicity	Virginia	VOPA Caseload
White	72.3	66.7%
African American	19.6	26.8%
American Indian/Alaska Natives	0.3	<1%
Asian	3.7	<1%
Native Hawaiin/Pacific Islander	.1	0
Latino	4.0	1.3%
Other	4.7	1.1%

(Stats are based on 2000 US Census and VOPA FY04 client caseload.)

C. Did your activities result in an increase of minorities in the following categories?		
Staff	yes __	no X
Advisory Council	yes __	no X
Governing Board	yes __	no X
Clients	yes __	no X

D. PAIMI Program Implementation Problems:

1. External Impediments: Describe any problems with implementation of PAIMI mandated activities, including those required under Parts H and I of the Children's Health Act of 2000, pertaining to requirements related to incidents involving seclusion and restraint and related deaths, (e.g., access issues, delays in receiving records and documents, etc.):

a) VOPA's right to access private facilities is continually questioned.

b) The scope of VOPA's access to records (particularly those records that facilities may wish to characterize as "peer review" or "confidential personnel records") is still a source of hindrance, delay, and refusal to cooperate.

c) VOPA continues to receive opposition from some DMHMRSAS facilities and from private

facilities and providers. VOPA has had to threaten litigation on some occasions to get access to its clients.

2. Internal Impediments: Describe any problems experienced in implementing PAIMI Program activities, including any identified annual priorities and objectives (e.g., lack of sufficient resources, necessary expertise, etc):

VOPA lacks the clinical expertise on staff to adequately review and assess medical records/evidence. Additionally, medical/psychiatric experts who are willing to undertake record reviews are extremely difficult to locate.

E. Accomplishments: Briefly describe the accomplishments for this fiscal year that resulted from PAIMI Program activities most important accomplishments.

Four VOPA staff have completed investigator training and obtained national certification. VOPA's ability to do the highest quality of investigations is critical to our advocacy on behalf of individuals with disabilities.

Currently, Critical Incident Reports come from the state institutions to VOPA via e-mail. The Department of Mental Health, Mental Retardation, Substance Abuse Services felt this method of reporting might violate client confidentiality. So, approximately 15 months ago, the Department met with VOPA and the Office of Inspector General to suggest another manner in which to report CIRs. They proposed that the institutions report through a Department database with VOPA and the OIG receiving the information through a web-based secured server. At that time, VOPA agreed to explore this, as long as there would be no change in the timeliness, level, quality, or amount of information provided. However, for reasons internal to the Department, this proposal was substantially delayed. Recently, the Department contacted VOPA to resume work on the secured server. We are in the process of fine tuning the delivery and receipt of the CIRs through this process. At present, we are waiting for some data elements. Once that clarification is received, VOPA will finalize their database and testing of "live" data can begin.

It should be noted that VOPA staff help patients in the State mental health institutions with a wide array of subjects when providing Information and Referral and Technical Assistance. Much of this is not reported in detail beyond the numbers. Some of the issues staff have dealt with at these service levels include: commitment appeal rights; the effect of commitment on civil rights like voting and firearms possession (Virginia has a significant rural geography); patient access to service record; Social Security and Veterans benefits problems; criteria and strategies for discharge from facility; discharge planning, and NGRI privileging matters.

VOPA has convened a committee of staff members to assist in the reviewing, revising and updating of the VOPA publications. The committee has agreed to some general guidelines, the most important being that the publications reflect one voice and one vision for VOPA.

F. Recommendations:
None at this time.

G. Technical Assistance needs requested.
None at this time.

SECTION IX. ACTUAL PAIMI BUDGET/EXPENDITURES FOR FY 2004

PAIMI Program Personnel

Position Title	Annual Salary	Percent/Portion of Time Charged to PAIMI	Costs billed to PAIMI
Executive Director	97,138	15.8%	15,348
Policy Director	63,395	33.00%	20,920
Managing Attorney	70,482	69.91%	49,274
Managing Attorney	68,264	21.90%	14,950
Staff Attorney	51,125	91.03%	46,359
Staff Attorney	55,166	1.33%	734
Staff Attorney	43,724	88.95%	38,892
Staff Attorney	35,695	0.97%	346
Staff Attorney	42,945	0.63%	271
Staff Attorney	30,097 (8 months)	6.70%	2,016
Staff Attorney	53,681	4.34%	2,330
Staff Attorney	45,145	97.83%	44,165
Disability Rights Advocate	31,701 (7 months)	25.91%	8,214
Disability Rights Advocate	30,685 (11 months)	78.48%	24,081
Disability Rights Advocate	32,383 (9months)	0.29%	94
Investigator	25,750 (10 months)	77.64%	19,992
Lead Resource Advocate	30,675 (9months)	27.06%	8,301
Resource Advocate	27,046	23.66%	6,399
Resource Advocate	27,622	27.88%	7,701
Paralegal	10,128 (4months)	6.59%	667
Business Manager	44,637	26.34%	11,757
Administrative Assistant	4833 (2 months)	31.99%	1,546
Administrative Assistant	29,584	27.10%	8,017
Administrative Assistant	13,749 (6 months)	31.23%	4,294
Administrative Assistant	17,124 (7months)	25.5%	4,367
Administrative Assistant	22,188 (9 months)	13.87%	3,077
Administrative Assistant	10, 729 (5 months)	48.3%	5,182
Data/Incident Analyst	43,445	35.0%	15,206
Receptionist	22,351	30.81%	6,886
Sub-Total	1,081,487	33.45%%	371,568
Vacant Positions	0		
Volunteer Positions	0		
Total Positions	1,081,487	33%	371,568

SECTION XI. ACTUAL PAIMI BUDGET/EXPENDITURES FOR FY 2004

CATEGORIES	COST
Fringe Benefits (PAIMI only)	105,723
Travel Expenses (PAIMI only)	13,415
SUBTOTAL	119,138

EQUIPMENT - TYPE (PAIMI ONLY)	COST
Computer	6585
Reference	30
Voice/Data Transmission	1383
Office	18
Electronic/Photographic	57
SUBTOTAL	8073

SUPPLIES - TYPE (PAIMI ONLY)	COST
Office	2,102
Stationary	1,094
Data Processing	866
SUBTOTAL	4,062

SECTION IX. ACTUAL PAIMI BUDGET/EXPENDITURES FOR FY 2004

Contractual Costs (including Consultants) for PAIMI Program Only					
Position or Entity	**Service Provided**	**Salary/Fee**	**Fringe Benefit Cost**	**Travel Expenses**	**Other Costs**
Legal Services	Depositions, court fees, etc.	521			
Attorney Services	Contract Attys.	22,171			
Employment Agency	Temp. Personnel	17,726			
Information Systems	Database design/develop.	5,135			
Expert Services	Medical	4,500			
Management Services	Interpreters, other experts, etc.	79,929			
Catered Meals	Board & Council meetings	475			
Advertising Services	Job Ads, Training/Outreach	428			

Equipment Maintenance Services	Maint. Contracts for Office Equipment	102			
State Gov’t Agencies	Services provided by other state agencies	46			
Subtotal		131,033			

Training Costs for PAIMI Program Only				
Categories	**#of persons/ Travel Costs**	**#of persons/ Training Costs**	**# of persons/ other expenses**	
Staff				
Governing Board				
Advisory Council				
Volunteers				
Subtotal				
TOTAL	220	1800		

Other Expenses (PAIMI Program only)	Costs
Litigation	
Shipping services, Telephones, Organization Memberships/Publication Subscriptions, Printing, Equipment/Office Space Rentals, Furniture, Recruitment Expenses	74,378
Indirect Costs	63,544
SUBTOTAL	137,922

Indirect Costs (PAIMI only): **Does your P&A have an approved Federal indirect cost rate?** Yes **What is the approved rate?** 16%

Total of All PAIMI Program Costs **$** 773,816

Income Sources and Other Resources (PAIMI Program Only)

PAIMI Program carryover from the previous Federal Fiscal Year(s) FY03	**$**376,945
Program Income	**$**
Interest on Lawyers Trust Accounts (IOLTA)	**$**
State	**$**
County Annual PAIMI Advisory Council Report	**$**
Private	**$**
Other (list)	**$**
Total of resources from all Sources	$376,945

.

*** State P&A systems that developed or amended their agency's practices or policies after submission of its most recent PAIMI Application , e.g., programmatic policy guidelines, fiscal, business management and/or other internal controls, by-laws, grievance procedures, are asked to include copies of these documents with their application.

Please see attached revised organizational chart.